## Medication Authorization

**Disaster Supply of Critical Medications**

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>First</th>
<th>Last</th>
<th>Weight:</th>
<th>Date of Birth and Age:</th>
</tr>
</thead>
</table>

### PRESCRIPTION INFORMATION

- **Medication:**
  - When to give:
- **Route:**
  - Dose:
- **Reason for medication:**
  - Expiration date of prescription:
  - Rotate or Replace date*:

**Possible side effects:**

**Allergies:**

**Special Instructions:**

**Notes:**

### MEDICAL PROVIDER

I have confirmed that this is a critical medication. The child named above may not be without this medication.

**Print Name:** _____________________________
**Phone:** _____________________________

**Signature:** _____________________________

Prescription label has medical provider’s complete information and name  ☐ YES  ☐ NO

### PARENT/GUARDIAN PERMISSION

- I hereby give permission for the child care staff to administer medication as prescribed above.
- I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medication.
- I have administered at least one dose of medication to my child without adverse effects. ☐ YES  ☐ NO

**Parent/Guardian Signature:** _____________________________
**Phone:** _____________________________

### OFFICE USE ONLY

- **Storage location:**
  - Locked  ☐ YES  ☐ NO
  - Refrigerated  ☐ YES  ☐ NO

**Amount received:**

**Medication received by:**

**Date:**

Indivdual Health Care Plan and Emergency Information

**up-to-date?**  ☐ YES  ☐ NO (update now)

**Amount received:**

**Medication received by:**

**Date:**

This authorization form expires **one year** from today on:

*Replace date is the date medication expires or the date the prescription expires-whichever comes first.*

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This form developed by Snohomish Health District
Child Care Health Outreach Program
3020 Rucker Avenue • Everett, WA 98201-3900 • www.snohd.org • tel: 425.252.5415
Dear Parent/Legal Guardian,

In the event of a major disaster in which your child may have to stay at child care, we will need a plan to care for your child and his/her special health care needs. Please discuss this subject with your child’s medical provider so that we can be prepared with medications, written prescriptions, or any necessary medical equipment your child may require.

If your child takes medications at home that we do not currently have at the child care which are critical to maintaining his/her health and well being, we would like to be prepared with at least a 3 day emergency supply as well as a signed authorization form (see other side).

Along with the signed Disaster Supply Medication Authorization, please bring the following:

- At least a 3 day supply of the medication
- Original container with child resistant cap
- Prescription label that includes the:
  - child’s first and last name
  - name of medication
  - dosage
  - instructions
  - schedule of when to give it
  - route of administration
  - date the prescription was filled
  - healthcare professional’s contact information
- Measuring device, if needed.

It is important that we communicate and have clear written instructions in your child’s individual health care plan; please make sure your child’s Health Care Plan and Emergency Information is up to date.

If you have any questions, please feel free to contact us.

Thank you.